



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

James D. Weiss, M.D.

**Respondent Name**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-17-0978-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 7, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "CPT Code 95885 and/or 95886 can be reported up to a combined total of four (4) units of service per patient ... Please also note that the claim has a Primary Procedure (NCV) listed."

**Amount in Dispute:** \$108.83

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOB(s) and the reduction rationale(s) stated therein."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2016	Evaluation & Management, new patient (99204)	\$0.00	\$0.00
July 22, 2016	Needle Electromyography, each extremity (95886)	\$91.93	\$91.93
July 22, 2016	Nerve Conduction Studies, 13 or more studies (95913)	\$0.00	\$0.00
July 22, 2016	Electrodes, per pair (A4556)	\$16.90	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 226 – Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete.

- B15 – This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
- 18 – Exact duplicate claim/service.
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

### **Issues**

1. What are the services in dispute?
2. What are the applicable rules for this dispute?
3. Is James D. Weiss, M.D. entitled to reimbursement for procedure code 95886?
4. What is the total reimbursement amount recommended for procedure code 95886?
5. Is James D. Weiss, M.D. entitled to additional reimbursement for procedure code A4556?

### **Findings**

1. James D. Weiss, M.D. included procedure codes 99204, 95886, 95913, and A4556 on the Medical Fee Dispute Resolution Request (DWC060). Dr. Weiss is seeking \$0.00 for procedure codes 99204 and 95913. Therefore, these services will not be considered in this dispute. Dr. Weiss is seeking \$91.93 for procedure code 95886 and \$16.90 for procedure code A4556. These services will be reviewed in accordance with applicable rules and guidelines for this dispute.
2. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:
 

for coding, billing reporting, and reimbursement of professional medical services, Texas Workers’ Compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; ... and other payment policies in effect on the date a service is provided...
3. Dr. Weiss is seeking \$91.93 for procedure code 95886. American Zurich Insurance Company (Zurich) denied reimbursement with claims adjustment reason code B15 – “THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED.”

Procedure code 95886 is defined as follows:

complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (List separately in addition to code for primary procedure)

CPT code requirements further state, “Use 95885, 95886 in conjunction with 95907-95913.” Review of the submitted documentation finds that procedure code 95886 was billed with procedure code 95913. The division concludes that Zurich’s denial of payment for this procedure code is not supported. Therefore, Dr. Weiss is eligible for reimbursement in accordance with applicable fee guidelines found in 28 Texas Administrative Code §134.203.

4. 28 Texas Administrative Code §134.203(c) states,
 

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the division conversion factor. The division conversion factor for 2016 is \$56.82.

For CPT code 95886 on July 22, 2016, at the billed location, the relative value (RVU) for work of 0.86 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.876340. The practice expense (PE) RVU of 1.68 multiplied by the PE GPCI of 1.006 is 1.690080. The malpractice RVU of 0.04 multiplied by the malpractice GPCI of 0.955 is 0.038200. The sum of 2.604620 is multiplied by the division conversion factor of \$56.82 for a MAR of \$147.99. This total is multiplied by 4 units for a total reimbursement of \$591.96.

Review of the submitted explanations of benefits dated August 2, 2016 and August 15, 2016 finds that the insurance carrier paid \$0.00 for this procedure code. Dr. Weiss, on his Medical Fee Dispute Resolution Request (DWC060), indicated that he is seeking reimbursement of \$91.93 for this procedure code. This amount is recommended.

5. Dr. Weiss is seeking \$16.90 for procedure code A4556. Per submitted Explanation of Benefits dated August 15, 2016, this service was reimbursed at the requested amount. No additional reimbursement is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$91.93.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$91.93, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____	_____ Laurie Garnes	_____ January 11, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**